Montana Department of Public Health & Human Services
SUBSTANCE ABUSE MANAGEMENT SYSTEM

CLIENT ADMISSION FORM

Name:					Account #:				
Program #					Facility				

DEMOGRAPHICS

3. Admission Date *(mmddyyyy)*

5. Case Number

10. County of Residence

13. Living Arrangement *(check one)*

☐ *Homeless* ☐ *Dependent Living* ☐ *Independent Living*

14. Employment Status *(check one)*

☐ *Employed Full Time* ☐ *Employed Part Time* ☐ *Public Assistance Benefits Depleted*

☐ *Unemployed* ☐ *Not in Labor Force*

15. Detailed Not in Labor Force *(check one)*

☐ *Homemaker* ☐ *Student* ☐ *Retired*

☐ *Disabled* ☐ *Inmate* ☐ *Other*

17. Has the client participated in a self-help group, support group (e.g., AA, NA, etc.) in the last 30 days? ☐ *Yes* ☐ *No*

TREATMENT AND REFERRAL

18. Days Waiting to Enter Treatment:

Is client waiting for a higher level of care *(check one)*: ☐ *Yes* ☐ *No*

19. Number of Prior CD Treatment Episodes

20. Admission Status *(check one)*:

☐ *Voluntary* ☐ *Forced Voluntary* ☐ *Involuntary (commitment)* ☐ *Court Order*

21. IV Usage *(check one)*:

☐ *Never* ☐ *Not in the last 12 months but since 1978*

☐ *During the last 12 months* ☐ *Not since 1978 but before 1978*

22. Is the Client Adversely affected by his/her gambling? *(check one)*: ☐ *Yes* ☐ *No*

23. Agency Referral Source *(Write Description)*

24. Program Referral Source *(Use Program Table)*

25. Detailed Criminal Justice Referral *(check one)*

☐ *State/Federal Court* ☐ *Diversionary Program*

☐ *Other Court* ☐ *Prison*

☐ *Probation/Parole* ☐ *DUI/DWI*

☐ *Other Recognized Legal Entity* ☐ *Other*

26. Number of arrests in the last 30 days

CLIENT ADMISSION FORM

Name:					Account #:			
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FINANCIAL / ELIGIBILITY

27. Household Income from all sources *(Annual)*

☐ Client refused to give income related information.

28. Pay Frequency *(check one)*

☐ *Weekly* ☐ *Every Two Weeks* ☐ *Bi-Monthly*
☐ *Monthly* ☐ *Annually* ☐ *Day Labor*

29. Including yourself, how many dependents are in your household?

30. Primary Source of Income *(check one)*

☐ *Salary* ☐ *Public Assistance* ☐ *Retirement/Pension*
☐ *Disability* ☐ *Other* ☐ *None*

31. Primary Source of Payment *(check one)*

☐ *Medicaid* ☐ *Other Government Pay*
☐ *Worker's Comp* ☐ *Other Health Insurance*
☐ *No Charge* ☐ *Other*
☐ *Self-Pay* ☐ *BCBS*
☐ *Medicare* ☐ *Unknown*

32. Health Insurance *(check one)*

☐ *Blue Cross/Blue Shield* ☐ *Other Private Insurance* ☐ *Medicare*
☐ *Medicaid* ☐ *IHS* ☐ *None*
☐ *Insurance Benefits Depleted* ☐ *CHIP*

INTERIM SERVICES

TB Services
☐ *Referral for Testing* ☐ *Counseling and Education*

Pregnant Women
☐ *Referral for Testing* ☐ *Counseling and Education*

IV Drug User
☐ *Referral for Testing* ☐ *Counseling and Education*

CRITICAL POPULATIONS

Check All That Apply

☐ *a. DUI Offender*
☐ *b. Receiving Food Stamps*
☐ *c. Receiving Medicaid*
☐ *d. Receiving AFDC*
☐ *e. Receiving SSI**
☐ *f. IV Drug User**
☐ *g. Protective Services Case*
☐ *h. Probation*
☐ *i. On Parole*
☐ *j. On Pre-Release*
☐ *k. Other Incarcerated Person*
☐ *l. Pregnant Woman**
☐ *m. Woman w/Dependents**
☐ *n. Homeless**
☐ *o. Mandatory Monitoring*
☐ *p. Receiving SSDI**
☐ *q. Infected AIDS**